

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Wright
Township Mountgassery
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 971 File No. 30529
Primary Registration District No. 6277 Registered No. 1

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Dollie Trumbo

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED OR DIVORCED Single
(Write the word)

DATE OF BIRTH March 30th 1904
(Month) (Day) (Year)

AGE 7 yrs. 4 mos. 12 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE
(City or town, State or foreign country) Wright Co., Mo.

PARENTS
NAME OF FATHER Wm S. Trumbo
BIRTHPLACE OF FATHER Lawrence Co. Illinois
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Maggie Longwell
BIRTHPLACE OF MOTHER Owego N.Y. York
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W S Trumbo
(ADDRESS) Mingsville Mo

Filed August 11th 1911 Algara Tarish
D^H REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 11th 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 12th 1911, to Aug 10th 1911, that I last saw her alive on Aug 10th 1911, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) ____ yrs. 1 mos. 7 ds.

Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R. B. Lynch M. D.
Aug 11th 1911 (Address) Plato Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Chappell Cemetery DATE OF BURIAL _____ 191__

UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



County Might Registration District No. 911 File No. _____
 Township Moltzowery Primary Registration District No. 6227 Registered No. 1
 or _____
 Village _____
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Dollie Trumbo

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)
 DATE OF BIRTH March 30, 1904
(Month) (Day) (Year)
 AGE 7 yrs. 4 mos. 12 ds. If LESS than 1 day, _____ hrs. or _____ m.
 OCCUPATION (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Might Co. Mo.

PARENTS
 NAME OF FATHER W. S. Trumbo
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Laurens Co. Mo.
 MAIDEN NAME OF MOTHER Maggie Longwell
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Albany N. York

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. S. Trumbo
 (ADDRESS) Mingsville Mo

Filed August 11, 1911 Algara Crisp
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 11, 1911
(Month) (Day) (Year)

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(Duration) _____ yrs. 1 mos. 7 ds.

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(Signed) R. B. Lynch M. D.
Aug 11, 1911 (Address) Plato Mo

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Chappell Cem. DATE OF BURIAL Aug 11, 1911

UNDERTAKER None but Neighbor ADDRESS Mingsville Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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